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## **Just healthcare? The moral failure of single-tier basic healthcare**

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**Abstract:** This article sets out the moral failure of single-tier basic healthcare. Single-tier basic healthcare has been advocated on the grounds that the provision of healthcare should be divorced from ability to pay and unequal access to basic healthcare is morally intolerable. However, single-tier basic healthcare encounters a host of catastrophic moral failings. Given the fact of human pluralism it is impossible to objectively define 'basic' healthcare. Attempts to provide single-tier healthcare therefore become political processes in which interest groups compete for control of scarce resources with the most privileged possessing an inherent advantage. The focus on outputs in arguments for single-tier provision neglects the question of justice between individuals when some people provide resources for others without reciprocal benefits. The principle that only healthcare that can be provided to everyone should be provided at all leads to a levelling-down problem in which advocates of single-tier provision must prefer a situation where some individuals are made worse-off without any individual being made better-off compared to plausible multi-tier alternatives. Contemporary single-tier systems require the exclusion of non-citizens, meaning that their universalism is a myth. In the light of these pathologies it is judged that multi-tier healthcare is morally required.

**Keywords:** healthcare; ethics; egalitarianism; universalism; subjectivity; pluralism; exclusion; levelling-down; justice; need

## **1. Introduction**

Single-tier basic healthcare describes the provision of one, universal standard of healthcare that is guaranteed to all as a right of citizenship. This may be provided either via direct state provision funded from compulsory taxation and provided free at the point of delivery, or via a system of national health insurance in which all citizens beyond a certain income level are required to contribute to health insurance and citizens below that level receive subsidized insurance.

By contrast, multi-tier systems of healthcare involve the simultaneous provision of different 'quantities' or 'qualities' of healthcare. This may occur via the existence of a market-based system of insurance, saving, and/or payment that leads to a plurality of provision so that

people with the same condition may receive different treatments depending upon their purchasing decisions (including ability to pay) in the marketplace.

The healthcare systems of most contemporary European social democracies, such as Denmark, France, Italy and the UK, aspire to provide single-tier basic healthcare. The constitution of the UK National Health Service (NHS), for example, states: 'The NHS provides a comprehensive service available to all... based on clinical need, not an individual's ability to pay' (Department of Health, 2012, 4). The German national health insurance scheme similarly aims to ensure that all German citizens receive the national standard of provision irrespective of individual income or wealth (Busse, Blumel and Stock, 2011).

In most contemporary social democracies citizens with sufficient resources may purchase additional, alternative and/or superior healthcare via private providers. This may be politically controversial – in the UK, for example, cancer patients who made 'co-payments' to privately fund drug treatments not offered by the NHS were for a time denied further NHS treatment (Meadowcroft, 2008, 441) – but it is very rare for private 'top-ups' to be outlawed.

This article is concerned with the preliminary question of whether the state should provide single-tier basic healthcare, rather than the secondary question of whether supplementary private provision is permitted. However, the issue of co-payments does speak to the question of what constitutes 'basic' healthcare that is a central concern of this article.

Single-tier basic healthcare is usually advocated on moral grounds, with two linked arguments usually advanced in its support: (1) the provision of basic healthcare should be divorced from ability to pay; and (2) unequal access to basic healthcare is morally intolerable. It is argued that these two principles lead to a compelling moral case for the state to directly provide or guarantee a universal standard of basic healthcare.

This article challenges the belief that single-tier basic healthcare is morally required. The standard ethical arguments for single-tier basic healthcare are elaborated in Section 2 before the following three sections show why these arguments should be rejected. Section

3 will argue that it is impossible to objectively define 'basic' healthcare and Section 4 will show that consequently healthcare resource allocation becomes a political competition between different interest groups that generates questions of justice between individuals when some people are required to assume burdens without reciprocal benefits. Section 5 will show that the egalitarian demands of single-tier healthcare create a levelling-down problem in which advocates of single-tier provision must prefer a situation where there is less total healthcare, less total well-being and some individuals are made worse-off without any person being made better-off than plausible multi-tier alternatives. Section 6 will draw upon the work of Hanson (2002) to argue that the widely-held intuition that healthcare is special is in reality a self-serving and in-group orientated remnant of human psychological evolution. The exclusion of non-citizens from single-tier healthcare in contemporary social democracies is evidence of the partial nature of the 'universalism' of such systems. A final concluding section will argue that the pathologies of single-tier basic healthcare mean that multi-tier healthcare is the most desirable model of healthcare provision.

## **2. The ethical case for single-tier basic healthcare**

At the heart of the account of the moral superiority of single-tier basic healthcare is the notion that healthcare is special and this specialness means that, unlike other goods and services, healthcare should not be provided by the market. Informing this viewpoint is a powerful and widely-held intuition that inequalities that may be tolerable in respect of access to other goods and services are intolerable in the case of healthcare.

Matthews (1998, 155-6), for example, has argued that while no one would consider it an injustice for chocolate cake to be provided by the market and thereby only be available to those people willing and/or able to pay for it, it is widely held that 'an injustice is done when healthcare resources are allocated unequally', so that 'a health care system available to all free at the point of delivery is morally justified, indeed required'.

Similarly, Daniels (1981, 146) has argued that there is a widely-held belief that 'health care is "special,"' and, 'should be treated differently from other social goods', so that, 'even in societies in which people tolerate (and glorify) significant and pervasive inequalities in the

distribution of most social goods, many feel there are special reasons of justice for distributing health care more equally’.

Empirical research by Lynch and Gollust (2010) has suggested that notions of blame or fault are important determinants of these popular intuitions about the justice or otherwise of different models of healthcare provision. In a survey of American citizens, Lynch and Gollust (2010, 870) found that 70 per cent of respondents believed that differential access to healthcare was unfair, but only 31 per cent of respondents thought differential life expectancy was unfair. Lynch and Gollust argued that this disparity reflected the popular perception that life expectancy was to a large extent determined by individual choices, so that a person may be held responsible for lowering their life expectancy through poor lifestyle choices, whereas access to healthcare was not judged a matter of personal responsibility.

Market provision of healthcare is therefore rejected because it does not satisfy the criterion of equal access to all: ‘a market system denies access to medical treatment to those who are unable to pay for it... Under the market system, freedom of choice only really exists for those who have the ability to pay’ (Matthews, 1998, 156).

Similarly, Stone has argued that the use of market forces in healthcare is morally intolerable because competitive pressures would allocate resources on the basis of ability to pay rather than clinical need:

[M]arket ideology turns the health care system into a competition between the rich and the poor instead of an orderly distribution of medical care according to clinical need... market ideology is the biggest obstacle to health care equity because in market theory, distribution is not supposed to follow need. It is supposed to follow economic demand (Stone, 2005, 66).

Single-tier basic healthcare is therefore advocated on the basis that the provision of basic healthcare should be divorced from ability to pay and unequal access to basic healthcare is

morally unacceptable. Hence, the requirements of equity are said to lead to a moral argument for single-tier basic healthcare.

However, more work may still be required to show why this argument applies only to healthcare and not to the provision of other essential goods and services, such as food, clothing and housing. Many of the arguments for the provision of healthcare outside the market would seem to be arguments against markets *per se*, rather than arguments against markets in healthcare.

Daniels (1981; 1985) has sought to establish the uniqueness of healthcare by utilising the Rawlsian idea of fair equality of opportunity. In Rawls' (1999) theory of justice, in what has become known as 'the difference principle', Rawls argued that social and economic inequalities may be justified if they are to the benefit of the least advantaged and 'attached to offices and positions open to all under conditions of fair equality of opportunity' (Rawls, 1999, 302). Rawls argued that strict economic equality may not be to the benefit of the least advantaged because differential rewards may be necessary to incentivise the most productive members of society to maximise their contribution to the generation of wealth: 'each society has a redistribution policy which if pushed beyond a certain point weakens incentives and thereby lowers production' (Rawls, 1999, 142).

Rawls excluded healthcare from his analysis, however, stating that in his identification of the least advantaged he assumed, 'that everyone has physical needs and psychological capabilities within the normal range, so that questions of health care and mental capacity do not arise' (Rawls, 1999, 83-4). Daniels (1985, 43-8) has argued that Rawls' exclusion of healthcare from his analysis was a simplification intended to enable him to establish a straightforward, idealized argument for distributive justice. Rawls's simplifying assumption, Daniels has contended, did not preclude the extension of his analysis to more realistic and complex situations, such as the provision of healthcare, once the foundational principles had been established. Indeed, Daniels argued that the importance that Rawls attached to fair equality of opportunity within his theory of justice demanded that the analysis be extended to healthcare given its impact on life chances.

According to Daniels (1985, 42-3), healthcare is special because it is a paradigmatic example of a primary social good that must be present if people are to enjoy 'species-typical normal functioning'. It is argued that, 'health care promotes health (or normal functioning), and since health contributes to promoting opportunity, then health care protects opportunity', so that, 'If justice requires society to protect opportunity, then justice gives special importance to health care' (Daniels, 2008, 29). As Stone (2005, 68) has put it, the specialness of healthcare comes from the fact that, 'health is a pre-requisite to everything else that we value in life... people cannot earn, merit, or deserve if they cannot function in the first place'.

It is argued, then, that healthcare is special because it impacts on life opportunities more profoundly than other goods or services. For this reason, it is claimed that unequal access to healthcare cannot be tolerated and universal provision of single-tier basic healthcare is morally required. On this basis it is said that popular intuitions about the specialness of healthcare can be cast into moral arguments that articulate the view that justice requires the provision of single-tier basic healthcare.

### **3. What constitutes 'basic' healthcare?**

If it has been established that single-tier basic healthcare is a moral requirement, the question that then follows is what constitutes 'basic' healthcare? The advocates of single-tier basic healthcare must draw a boundary separating basic healthcare and non-basic healthcare if the costs of such a system are to be controlled.

The experience of the UK National Health Service is instructive here. On its foundation in 1948, the NHS was designed to be free at the point of use with no explicit limit on the resources that could be consumed by an individual or by the system as a whole. The architects of the NHS believed that the cost of the system would decrease as the backlog of ill-health was cleared and preventative medicine and public health measures reduced future morbidity. The reality of the NHS proved much different, however. The cost of the NHS quickly became unmanageable leading to the introduction of charges for prescriptions and optical services within three years of its creation. Despite the continuation of these charges



the net cost of the NHS has continued to rise inexorably, from three per cent of GDP in 1948 to seven per cent of a significantly larger GDP sixty years later (Crisp, 2002; Culyer, 1976, Chapter 2; Malone and Rycroft-Malone, 1998; Meadowcroft, 2008).

Without some restraint healthcare costs will rise relentlessly because chronic conditions can act as an unlimited drain on resources. As Brock (2001, 166-7) has noted, amongst individuals 'with very severe cognitive and physical impairments who have a very low health related quality of life, there may be almost no end to the resources that might be devoted to them in the form of health care, medical research, and other supportive services'. Similarly, endless resources can conceivably be devoted to achieving relatively minor health gains for people who consider themselves to be in reasonably good health.

Advocates of single-tier basic healthcare have argued that it is possible to establish a list of objective clinical needs that will be met by such a system. Daniels (1981; 1985) has argued that it is possible to make a distinction between needs that are objectively ascribable and objectively important and those that are only subjectively ascribable and subjectively important – only the former would be treated by a single-tier system. An individual's need for root canal treatment, for example, is said to be objectively ascribable because it can be diagnosed by a trained professional. This need is also said to be objectively important because, again, a trained professional can attest to the pain and the complications that will follow if treatment is not provided. An individual's need to revisit the neighbourhood of their childhood, on the other hand, is neither objectively ascribable nor objectively important. While the individual concerned will be aware of this need and will experience its urgency, these feelings are said to be purely subjective (Daniels, 1981; Daniels, 1985, Chapter 3).

Daniels argued that this analysis can be developed to identify a category of objectively ascribable and objectively important needs that enable a person to '[maintain] a normal range of opportunities' within a given society (Daniels, 1981, 154). On this basis, Daniels (1981, 157) argued that a dysfunctional nose 'might warrant treatment as an illness' if it was outside the normal species functions and anatomy, and thereby, one assumes, prevented an individual from accessing the normal range of opportunities. But it is argued that 'deviation

of nasal anatomy from individual or social conceptions of beauty does not constitute disease', so cosmetic correction would not be regarded as a health need to be met within a single-tier basic healthcare system.

The advocates of single-tier basic healthcare assume that objective health needs can be identified and objective treatments accordingly prescribed, so that basic healthcare can be defined: 'medicine is a science... This means that a standard of need can be arbitrated clearly and fairly. Each medical problem has a proper remedy; each person should get that remedy (or test, procedure, etc.) that is appropriate to his or her problem' (Stone, 2005, 68-9).

In reality, however, it is impossible to establish a set of health needs that are objectively ascribable and objectively important. There are numerous different definitions of what constitutes a health need, ranging from a medical condition that expert clinical opinion decides merits treatment, to any state of health that falls below a particular standard of good health (Culyer, 1976, Chapter 2; Meadowcroft, 2005a).

Moreover, what expert clinical opinion decides merits treatment is subject to enormous geographical, cultural and diachronic variation. For example, in Europe and North America in the nineteenth and early twentieth centuries, masturbation was considered by expert clinical opinion to be a life-threatening medical condition that demanded medical intervention, including, in extreme cases, surgery (Engelhardt, 1974; Stengers and van Neck, 2001). Similarly, the existence and diagnosis of what was originally termed myalgic encephalomyelitis (ME), and is now known as chronic fatigue syndrome (CFS), has been a matter of controversy within the medical profession of most developed countries for a number of decades (Evengård et al, 1999).

What constitutes a general standard of good health is also not fixed. While there is evidence, for example in terms of rising life expectancy, of significant advances in health and well-being in contemporary developed societies, there is also counter-evidence that points to a decline in levels of health and well-being, such as the increase in the numbers of people receiving welfare payments because they are judged unable to work due to disability or ill-

health. In the UK, for example, claimants of Disability Living Allowance have risen from just above one million people in 1992 to just under three million in 2008. While this threefold increase in welfare claimants on the grounds of disability raises a whole series of social policy questions beyond the scope of the present article, this rise does seem to reflect differing expectations as to what constitutes disability and the accepted standard of good health required for labour force participation.

Likewise, Daniels' (1981; 1985) example of nasal anatomy that does not meet popular concepts of beauty as a health need that is not objectively ascribable and not objectively important seems questionable given the evidence that physical appearance plays an important role in determining people's life chances (for example Hamermesh, 2011). There would seem to be a strong argument on Daniels' own terms for describing cosmetic interventions designed to make people look more beautiful as objectively ascribable and objectively important given the life opportunities that physical attractiveness may bestow. The point is not that Daniels is right or wrong in this particular instance, but that what constitutes a health need requiring clinical intervention is inherently subjective.

Not only is there no consensus as to what constitutes medical need, or the urgency of different medical needs, but, as Shapiro (2007, 136) has pointed out, different individuals will wish to make different trade-offs between healthcare and alternative uses of resources:

Those who are more risk averse will likely devote more resources and time to health care and their relationship with their health-care providers; those who are less risk averse are less likely to do so. All of these differences would seem to imply a role for widespread choice in the health-care system...

What follows is that there is no objectively correct trade-off to be made between healthcare and other possible uses of scarce resources. Rather, there are a myriad of possible trade-offs that reflect different individual approaches to risk and different individual preferences for various ends, wants and needs.

The contention that health needs can be objectively determined by expert opinion, or some other deliberative process, is a fundamental misconception. In reality, as Engelhardt (1996, 190) has put it, 'medical facts... are not timeless truths, but data given through the formative expectations of our history and culture. Recognizing a state of affairs as heart disease, cancer, depression, homosexuality, or tuberculosis is a rich and complex process'. The case for single-tier provision of basic healthcare requires denial of the pluralism and subjectivity of human experience and how this plays out in the realm of health and well-being.

A fundamental and insurmountable problem for single-tier basic healthcare is that it is impossible to objectively establish what constitutes basic healthcare. However, those managing the single-tier healthcare systems of contemporary social democracies must attempt to make such judgements if such systems are to operate and control costs. Examination of the real world operation of such processes further undermines the case for single-tier basic healthcare.

#### **4. The provision of 'basic' healthcare and justice between individuals**

Those managing the single-tier healthcare systems of contemporary social democracies must make central, deliberative decisions about what conditions will be treated and what treatments will be provided despite the fact that objectively ascribable and objectively important health needs cannot be established. In the UK, for example, the National Institute of Clinical Excellence (NICE) issues guidelines on what treatments the NHS will fund for different conditions using basic cost-effectiveness analysis (Meadowcroft, 2008; Rawlins and Culyer, 2004).

In the absence of an objective basis for such decision-making, resource allocation within such a system becomes a political process in which different interest groups compete for control of scarce resources. Those groups that are able to effectively mobilise to capture the deliberative process will be able to secure substantial resources for the treatment of particular conditions, whereas those groups unable to mobilise so effectively will receive relatively limited resources.

This is one explanation of why in the UK NHS, for example, the treatment of some conditions, such as Parkinson's Disease, may be judged world-leading, whereas the treatment of others, such as lung cancer, produces survival rates among the lowest in the developed world. An important factor in the relative allocation of resources to Parkinson's care and lung cancer treatment is the different socio-economic profiles of those who suffer from the two conditions. Resource allocation via the political process privileges the demands of those with the relevant economic, social and/or cultural resources (Meadowcroft, 2008).

Even when questions of resource allocation within a single-tier basic healthcare system are addressed in the theoretical literature, the problem of justice between different groups arises. Daniels' (1981; 1985) privileging of life opportunities in his argument for healthcare exceptionalism, for example, leads to the conclusion that greater importance should be attached to the health needs of the young relative to the health needs of the old. This raises particular difficulties given that a large proportion of healthcare expenditure is used to alleviate pain and suffering in the final months of life and to postpone death as long as possible. As Segall has pointed out, it is hard to see how such treatment can be judged special in terms of Daniels' criterion of achieving fair equality of opportunity:

Most patients treated by health care systems are individuals in the twilight of their lives. Furthermore, it is also the case that the bulk of health care resources are spent on these elderly patients... Health care in that case cannot be said to provide opportunity, equal or otherwise, to pursue *life plans* (Segall, 2007, 347-8).

Indeed, Daniels' (1985, 88) has gone so far as to argue that 'an *age-relative opportunity range*' might be used by 'prudent planners' to assess the level of healthcare to be provided to the elderly relative to that provided to the young. This would mean that people above a certain age would be denied life saving and other treatments (unless they had recourse to private finance to fund those treatments).

The notion that 'prudent planners' will dispassionately and omnisciently decide who should and should not receive healthcare presents an extremely naïve view of the practical reality of deliberative rationing in single-tier healthcare systems described earlier in this section.

Moreover, within Daniels' model it will be possible for a citizen to make no demands on a national healthcare system throughout their working life and then to be denied treatment in their old age. Such an individual will have contributed in tax to the provision of other people's healthcare, but will receive no provision in return. It is difficult to see that this state of affairs is just.

This is a particularly striking example of a more general problem faced by moral theories that focus on outputs but do not take into account the inputs required to produce those outcomes. Proposals for single-tier basic healthcare like those set out by Daniels seem to assume that the resources required to provide healthcare are manna from heaven that have fallen unowned from the sky, when in reality resources are created through the labour of individual men and women and such wealth creation in turn creates entitlements. If a particular individual or group creates resources that are used to provide healthcare to others, then questions regarding the justice of the relationship between producers and consumers must arise.

In ethical evaluation of questions of public finance like the provision of national systems of healthcare it is necessary to examine the balance-sheets of individual men and women in order to appreciate the individual contributions made and the individual disbursements received. Macro-analysis of aggregate statistics, such as national expenditure on healthcare, inevitably fails to take into account the net contributions/receipts of particular individuals. As Buchanan (1958, 33) has written in the context of aggregate analyses of public debt liabilities:

[T]he effect on the national balance sheet is operationally irrelevant... the nation or community is not a sentient being, and decisions are not made in any superindividual or organic way. Individuals and families are the entities whose

balance sheets must be examined if the effects on social decisions are to be determined.

It is necessary to examine the distribution of benefits and burdens between individuals in order to arrive at an accurate assessment of the justice of a particular system of healthcare provision. A healthcare system in which particular individuals are required to labour to fund the treatment of others who do not bear similar burdens, faces important questions regarding the justice of such arrangements. There may be particular circumstances in which such arrangements are perfectly just, for example if some people volunteer to provide for others, but work is required to bring forward such justifications that has not been done by the advocates of single-tier basic healthcare.

## **5. Egalitarianism and the levelling-down problem in healthcare provision**

As set out in Section 2 above, the underlying principle of single-tier basic healthcare is that everyone has access to identical provision. It is deemed to be morally wrong for one person to receive basic care that is not available to others – for example, because they are unable to pay for it. It follows from this position that (aside perhaps from experimental testing of new drugs or procedures) a particular healthcare treatment or standard should only be made available if it can be provided to all; a treatment that cannot be provided universally should not be made available to anyone.

As such, single-tier basic healthcare would seem to fall foul of Parfit's (1991; 1997) 'levelling-down' objection to egalitarianism. This objection may be illustrated with the formal example of the following two distributions of well-being (1) and (2) between three hypothetical people A, B and C, shown in Figure 1 below (setting aside the question of whether well-being really can be measured in such a precise way).

[Figure 1 about here]

Distribution (1) is the more equal of the two distributions, and therefore the distribution that egalitarians would logically prefer, but (2) has the highest overall well-being and A, the

person worse-off in both distributions, is better-off in absolute terms (though not in relative terms) in (2). The problem that Parfit identified is that the egalitarian must prefer the distribution of well-being in which everyone has less welfare, including the person at the bottom of the scale. This would seem to cast egalitarianism into the realm of the irrational and the welfare-reducing.

When applied to the provision of healthcare, the levelling-down problem would seem to be particularly acute. If the two distributions in Figure 1 are assumed to show the only two possible allocations of access to healthcare (again, assuming such access could be quantified in this way), then, again, the egalitarian must prefer the more equal distribution (1), even though (2) has the highest overall healthcare provision and A, the person worse-off in both distributions, receives access to superior healthcare in (2).

Moreover, the advocate of equal access to healthcare would also seem to prefer a distribution of healthcare resources in which some people are denied treatment that could be made available to them, but that resources would not permit to be made available to all. This problem is illustrated in Figure 2 below which shows the formal example of two distributions of healthcare resources (3) and (4) between three hypothetical people D, E and F.

[Figure 2 about here]

Here, the health egalitarian must prefer equal distribution (3) over unequal (4), even though individuals E and F will be denied access to treatment that they would have received in the latter distribution, because resources do not permit that level of treatment to be extended to D also.

A moral commitment to the principle that no one should be denied access to healthcare that is available to others inevitably leads to support for situations in which some people are denied treatment with no benefit flowing to others as a result of that denial. It would seem that the advocate of single-tier healthcare must take a position that is irrational and welfare-reducing in that it requires preference for a situation in which there is less total



healthcare, less total well-being and some individuals are made worse-off without any individual being made better-off as a consequence.

The problems posed for egalitarianism by the levelling-down objection led Parfit (1991; 1997) to adopt what he termed 'the priority view' as an alternative moral standpoint. This is the view that 'it is morally more important to benefit the people who are worse off' than to pursue strict equality of outcome or input (Parfit, 1991, 103). Giving priority to those in most need is judged more valuable than equality per se. The most influential prioritarian argument is that set out in Rawls' (1999) theory of justice, in which, as noted above, Rawls' difference principle stated that inequalities may be justified if they are to the benefit of the least advantaged members of society.

Prioritarianism raises some general philosophical questions, such as which group should be prioritised and on what basis,<sup>1</sup> but in the context of the present article the most relevant implication is that, unlike egalitarianism, prioritarianism does not require single-tier basic healthcare. On the contrary, as Shapiro (2007) and Pennington (2011) have argued, if we believe that multi-tier healthcare leads to a superior quality of provision for all than single-tier healthcare then a prioritarian like Rawls should support such a system on ethical grounds. The least advantaged would clearly benefit from an unequal system that delivered a higher quality of healthcare to all compared to one that provided equal access to universally inferior healthcare.

## **6. Moral intuition, healthcare exceptionalism and exclusion**

An important part of the case for single-tier basic healthcare set out in Section 2 is the claim that there is a common moral intuition that healthcare is special and therefore should not be subject to market forces. The notion that moral intuitions should be uncritically translated into public policy is, however, problematic.

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<sup>1</sup> Nozick's (1974, 194-5) critique of Rawls' prioritising of the least advantage is probably the most important critique of Rawls's prioritarianism.

Hanson (2002) has argued that there are often good reasons to be sceptical towards widely-held moral intuitions, rather than use them as the basis for moral theories that may ultimately inform public policy. Many moral intuitions reflect common biases in the non-scientific analysis of empirical data and/or are remnants of human psychological evolution which 'has left us largely unaware of how self-serving and in-group-orientated (i.e. favouring our own family, tribe, or ethnicity) the functions performed by those behaviours and intuitions were' (Hanson, 2002, 154).

According to Hanson (2002), the belief that healthcare is special may be an example of an intuition that appears to be other-regarding but is in fact self-serving. Hanson notes that the common concern for the health of others that is translated into political advocacy of single-tier basic healthcare does not extend to other comparable problems. There are charities devoted to practically every medical condition, but almost none devoted to other life crises, 'such as divorce, falling out of love, unemployment, failing in one's career, losing a friend, and so on' (Hanson, 2002, 165).

From the perspective of evolutionary psychology, this unique interest in the health of others, but not in other aspects of their well-being, is most logically explained by the personal benefits likely to be derived from other people's health. Hanson (2002) has argued that in the small groups within which humans evolved ensuring that one was surrounded by high status individuals was crucial to personal survival. In these small groups, high status was positively linked to good health, which meant that each individual had a powerful interest in the health of other members of their immediate group, but not in other aspects of their well-being, nor in the health of those outside the group. According to Hanson, it is these self-interested, in-group concerns that are the source of the common contemporary intuition that healthcare is special.

In the light of Hanson's analysis it is surely significant that healthcare exceptionalism is almost always applied at the national, but not the international, level. Although arguments for healthcare exceptionalism are framed in terms of the principle that *no one* should be denied access to healthcare on the basis of ability to pay, such as Matthews' (1998, 156) claim 'that an injustice is done when health care resources are allocated unequally, between

different income groups or between different geographical areas', the actual operation of single-tier basic healthcare systems is at odds with this normative position. Access to healthcare within contemporary social democracies is in fact only extended to citizens of these societies.

Hence, the legislation underpinning the UK NHS makes provisions for the UK government to charge non-citizens for the use of NHS services. As the UK Department of Health website advises:

If you are not ordinarily resident or exempt under the regulations, charges will apply for any hospital treatment you receive and cannot be waived. If this is the case you are strongly advised to take out private healthcare insurance that would cover you for the length of time you are in the UK. There is no facility to purchase healthcare insurance from the NHS therefore any necessary insurance must be organised privately.<sup>2</sup>

Access to state provided healthcare in contemporary social democracies, then, is not universal. The principle of universality only extends to citizens and those who temporarily meet the relevant residency requirements. People resident in these countries on short-term entry visas who do not meet the requirements of citizenship, for example, are excluded from treatment.

Moreover, millions of poor and needy people who happen to live in other parts of the world are excluded from entry to contemporary social democracies and are thereby excluded from access to these services. These millions of people are excluded from these healthcare systems because it would be financially impossible to grant them access and maintain the quality of care that the citizens of contemporary social democracies demand.

The exclusion of non-residents might be thought justifiable on the basis that they have not contributed to the provision of the relevant services, but, as shown above, single-tier basic healthcare is justified on the basis of universal moral principles, rather than on the basis of

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<sup>2</sup> [http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/Browsable/DH\\_074400](http://www.dh.gov.uk/en/Healthcare/Entitlementsandcharges/OverseasVisitors/Browsable/DH_074400)

the financial contribution made by particular individuals or groups; a citizen of a social democratic state who did not work a single day in their life and therefore did not contribute a penny of income tax would remain entitled to full access to healthcare.

This exposes the fact that the social democratic principle of inclusion is in fact a principle of exclusion. The quality of care provided by these healthcare systems can only be maintained if non-residents are excluded. This may be practically expedient but it should be morally troubling for advocates of these 'universal' systems. It is not clear on what basis there is a moral difference between a healthcare system that provides differential access to people within a single polity and a healthcare system that provides differential access to people across polities. The only substantive difference would seem to be the boundaries via which people are excluded.

In this respect the supposedly-universal healthcare systems of contemporary social democracies are an example of the insider-outsider division characteristic of contemporary social democratic welfare states. Those who are citizens of these countries have allocated themselves benefits that can only be maintained if less fortunate others are excluded. Curiously, this does not inhibit advocates of these systems from shamelessly employing moral arguments that appeal to principles of equality and universalism.

The fact that healthcare exceptionalism is only applied at the national level would seem to support Hanson's claim that the moral intuition that health is special reflects a self-serving and in-group-orientated preference. It is an intuition that should be critically interrogated rather than uncritically accepted.

## **7. Conclusion: the moral necessity of multi-tier healthcare**

This article has set out the moral failure of single-tier basic healthcare. It has shown that it is impossible to objectively define 'basic' healthcare. Consequently, single-tier healthcare systems engender a political process in which different groups compete to have their desired treatments classified as 'basic' healthcare. Those groups with superior resources for lobbying possess an inbuilt advantage in this process. The political allocation of resources to

different healthcare treatments also generates questions of justice between individuals when some people are required to assume burdens without reciprocal benefits; it is erroneous to examine aggregate healthcare outcomes without considering the contributions and receipts of particular individuals and families in the production and consumption of healthcare.

It was also shown that the egalitarian demands of single-tier healthcare create a levelling-down problem where a situation in which there is less total healthcare, less total well-being and some individuals are made worse-off without any individual being made better-off must be preferred to plausible multi-tier alternatives. Finally, it was argued that the widely-held intuition that healthcare is special is in reality a self-serving and in-group orientated remnant of human psychological evolution. The 'universal' healthcare systems of contemporary social democracies only operate via the exclusion of non-citizens unfortunate enough to be born outside of these particular polities. The moral basis for the exclusion of those individuals is unclear.

The catastrophic ethical failings of single-tier basic healthcare lead to the conclusion that multi-tier healthcare is morally required. There is no one correct method to deliver multi-tier healthcare. As Shapiro (2007, Chapters 3 and 4) has discussed at length, multi-tier healthcare can be delivered via a market for private health insurance in which a plurality of suppliers offer a variety of different insurance packages. As in other insurance markets, individuals and groups (for example, the employees of a particular organisation) may then choose the level and type insurance best suited to their personal preferences. Multi-tier healthcare can also be provided by charging for medical services, as is presently the case in the provision of cosmetic surgery, dental care and optical services in most countries. Charges may be met by saving plans or (where appropriate) via insurance services.

There is, then, no blueprint for how multi-tier healthcare should be delivered. Instead, a process of discovery should be set in motion towards a future that must ultimately be unknown and unknowable.

A multi-tier healthcare system reflects the inherently personal and subjective nature of health needs and the diverse range of possible treatments that may be provided in response to those needs. To suggest that a panel of experts (or some other deliberative process) can categorise some health needs as objectively ascribable and objectively important is to deny fundamental truths about the plurality of human ends because those truths do not fit a pre-determined view of how healthcare should be organised.

A multi-tier healthcare system enables some people to receive healthcare that cannot yet be provided universally. This does mean that the wealthy will be able to pay for treatments not presently available to those without similar resources – but given that these treatments would not be available to anyone in a single-tier system they represent a positive-sum gain compared to single-tier healthcare.

Moreover, by paying for treatments not presently affordable to all, the rich fund the development of treatments that will eventually be provided at a cost that is widely affordable. Just as a small number of wealthy pioneers first bought televisions, personal computers and mobile phones and by so doing demonstrated the demand for these products and funded their eventual production at much lower cost, multi-tier healthcare allows the same principle of experimentation, learning and speculative investment to operate in healthcare (Meadowcroft, 2005b, 75-77).

Advocates of single-tier basic healthcare have long assumed the ethical high ground, yet their arguments have failed to address the numerous moral problems inherent to any attempt to provide single-tier basic healthcare. This article has set out those moral problems and argued that the catastrophic moral failings of single-tier basic healthcare can only be avoided by the provision of multi-tier healthcare. It is multi-tier healthcare, not single-tier healthcare, that provides a just system of healthcare provision.

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**Figure 1: Two distributions of well-being among three people**

	A	B	C
1	10	15	20
2	11	15	25

Source: Adapted from Brock (2002, 364)

**Figure 2: Two distributions of healthcare resources among three people**

	D	E	F
3	10	10	10
4	10	12	14